OB/GYN SPECIALISTS LLP
ANNUAL UPDATE PATIENT INFORMATION FORM

AUTHORIZATION FOR RELEASE OF INFORMATION AND PAYMENT OF BENEFITS

Patient Name : _____Patient DOB:_____

I consent to medical examination and treatment for myself or for the patient for whom I am the parent or legally authorized representative. _____accept _____deny

I hereby authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS confidential information, necessary to process insurance claims or any medical information that is required for any health care related utilization review or quality assurance activities.
I consent to the use or disclosure of my protected health information by OB/GYN Specialists, LLP for the purpose of diagnosing and/or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations. I understand that diagnosis and/or treatment of me by OBGYN Specialists may be conditional upon my consent, as evidenced by my signature on this document. _____accept _____deny

I understand I have the right to request as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The practice is not required to agree to the restrictions that I may request; however, if OBGYN Specialists agrees to a restriction that I request then the restriction is binding. I have the right to revoke this consent, in writing, at any time except to the extent that the practice has taken action in reliance on this consent. _____accept _____deny

I understand that I have the right to review the Notice of Privacy Practices(NPP), which has been made available to me, prior to signing this document. The NPP is also posted at each office location and on the practice website at www.obgynspecialistsofmacon.com. The NPP also describes my rights and the practices duties with respect to my protected health information. _____accept _____deny

I, _____, whose signature appears below, authorize OBGYN Specialists, LLP and its Affiliated Providers to view my external prescription history via the RxHub service.
I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years. A photocopy of this authorization shall be considered as effective and valid as the original. _____accept _____deny

I hereby authorize the release of my Protected Health Information to the following individuals:

_____

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT. This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

_____
Patient Date

_____
Witness Date